

Tuberculosis, migration, and medical examination: lessons from history

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This article examines policies of health screening with particular reference to the "Australian model". It details how historical approaches can contribute to an understanding of contemporary public health policy.

The health screening of migrants, asylum seekers, and other entrants to the UK is currently high on the political and public health agenda. Two features of this debate are worth highlighting—the focus on single diseases such as tuberculosis, and the emphasis on the experience of Australia. In February 2005, the government announced proposals to implement existing powers by screening visa applicants for tuberculosis on "high risk" routes, and requiring those diagnosed to seek treatment before they would be permitted entry to the UK.¹ The Conservative party has also announced that visas would be denied to prospective migrants in whom tuberculosis was detected. Michael Howard stated that "the British people deserve the best standards of public health. We need to control who is coming to Britain to ensure that they are not a public health risk and to protect access to the NHS. It's plain common sense. And it's exactly what they do in New Zealand, Canada and Australia".^{2,3}

There is therefore considerable interest in "the Australian model", and policy in the UK has shifted to pre-entry screening for tuberculosis. The current law cannot be used to remove people once they have arrived, and policies have been drawn up to exclude before arrival. At the same time, it has been argued that there is little evidence on the benefits or drawbacks of a policy of pre-entry screening for tuberculosis, and disease should not be a basis for discrimination.^{4,5} This commentary reviews current Australian policy, explains its history, and compares it with the development of policy in the UK. The commentary argues that in the absence of scientific or medical evidence for screening efficacy, there are other explanations for why these practices developed in the past, and continue in the present.⁶ It further underlines how historical approaches can contribute to an understanding of contemporary public health policy.⁷

What, then, is the current Australian model of migrant health screening? In contrast with the UK, the health screening of (non-citizen) entrants to Australia is regulated less by public health law than by migration law, and has been since the 19th century. Currently, health screening is managed through a complex visa system. Except for a few categories (for example, diplomatic visas and certain emergency humanitarian visas) various criteria are applied that inform the issuing of visas. The nature of the health criteria, declarations, and diagnostic tests to be undertaken vary according to the length of stay in Australia, the category of visa sought, and the risk status of the country from which the visa is applied. Some entrants, from some countries, may simply "declare" their health and infectious disease status—usually on forms distributed en route. Applicants from countries deemed to be "very high risk", and who intend to stay over three months must fulfil the health criteria. Any applicant from any country who wishes to stay over 12 months—intending migrants, asylum claimants, international students, and those seeking long term residency—must likewise undertake a compulsory health screening process. In other words, the compulsory health criteria are the main reasons why visas are not issued. On 26 March 2004, a new set of regulations detailing prescribed "symptoms", as well as SARS and smallpox, were added to the longstanding list of "prescribed diseases".^{8,9}

There are four points to emphasise about the processes and the substance of Australian health screening. Firstly, this screening is compulsory under the 1958 Commonwealth Migration Act. Interestingly in Australia, this compulsion currently engenders very little public or political debate, although it has in the past. Secondly, law and regulation recognise a "public charge" argument, as well as a public health

argument, in refusing entry to people with certain diseases and conditions. That is, the question of possible public expense is taken into consideration. Thirdly, and importantly in this context, what distinguishes the Australian model is that this screening and examination takes place "offshore", in the Australian parlance. All intending migrants, international students, and long term residents must apply for a visa, undertake all tests, and undergo any resulting treatment in their original country of application. Where a visa is applied for can make considerable difference to the required criteria and outcome. Fourthly, and related to the previous point, tuberculosis control has long occupied an exceptional place in Australian migration regulation. While the exclusion of a person with any other communicable disease may be waived by ministerial discretion, there is a "no exception, no exemption" policy with respect to tuberculosis of any kind. An applicant with active disease must undertake chemotherapy, and be re-tested before a visa can be granted—that is, before entry into Australia is possible.¹⁰ The broad risk categorisation of countries (where Australia is "low risk") is determined by the incidence of tuberculosis. In practice then, although not by design, this directly affects the national (and therefore the ethnic) composition of entrants to Australia.

How and why did this Australian model arise? Apart from the indigenous community, Australia is a nation of immigrants. This means that there is a strong tradition of migration law, policy, and regulation stretching back into the early 19th century. From about the 1880s, Migration Acts in the then six British colonies (Australia only became federal in 1901) were increasingly concerned with two things—disease and race. All the colonies had some version of a Chinese Exclusion Act, the rationale for which was partly public health and communicable disease control. Smallpox and leprosy specifically were understood to be brought to Australia by Chinese immigrants.¹¹ The new 1901 Immigration Restriction Act, which was the legal basis of the White Australia policy, had a public health power: the "loathsome diseases" section (3d). Thus in Australia, the connections between public health, migration, and race were explicit, legal, and technical, rationalised by the epidemiology and science of the times.

Many if not most countries made similar connections between race, disease, and migration in law and practice. Historians have argued that Australian geo-politics is part of the explanation for the particularly strong version of this

international phenomenon. Firstly, the island status of the continent is crucial. British (that is white) settlers in the Asia-Pacific region felt the need to assert their racial difference stridently, and constantly felt that their borders were under threat. Secondly, the island status of Australia also gave rise to rigid maritime quarantine practice (still in place with respect to animals and goods via airports and sea) to keep diseases out. In many respects this was successful; cholera, for example, never entered the island continent. The practice of gaining entry permits, and undertaking health criteria “offshore” developed with respect to British applicants. The longstanding government and bureaucratic links between Australia and Britain offered the infrastructure for this kind of process, and it built up gradually over time. In the past two generations, as migration patterns have radically changed in Australia, these processes have eased with respect to British people, and transferred, multiplied, and intensified with respect to people from elsewhere, in particular those from “high risk” and “very high risk” countries.

What then is the UK model of migrant health screening? The British Thoracic Society’s Code of Practice recommends that all immigrants or other entrants from all countries other than the European Union, Canada, the USA, Australia, and New Zealand intending to stay longer than six months, and all refugees, should be screened, suggesting that an incidence of 40 per 100 000 population per year is an arbitrary but reasonable level above which tuberculosis might be considered common.¹² Under the 1971 Immigration Act, there are powers to require medical examination after entry if immigration officers are of the opinion that “a further medical test or examination may be required in the interests of public health”.¹³ Immigration officers can give migrants leave to enter the UK, but may require them to report their arrival to medical officers of health. Asylum seekers with no intended address are referred for screening at the port of entry. However, many new arrivals have addresses in the UK, and screening is meant to take place at the local level (what is called the port of arrival system). Forms are then forwarded to consultants in communicable disease control in the area within which the destination address lies. It is up to them to contact migrants and carry out follow up tests to find people who are positive on skin testing and those requiring vaccination, and to initiate chest radiography. It is not that the legislative framework for the application

of screening has changed, but that the strategy is now to strengthen pre-entry screening.

Nevertheless there is a noticeable difference between the guidelines recommended by the British Thoracic Society and what happens in practice. Studies have highlighted that only around a quarter of migrants to the UK are traced and screened for tuberculosis, and that the port of arrival system failed to identify 60% of new migrants to one area of the UK. Many tuberculosis clinics in liaison with consultants in communicable disease control do not arrange screening for the new entrants referred to them on the grounds that they do not have the resources or have other priorities. Many migrants do not attend screening because of changes of address, language difficulties, and mistrust of authorities.^{14 15}

It is important to understand how UK policy, mainly reliant on the port of arrival system, developed in the period after the second world war. It was partly epidemiological evidence, but more importantly professional bodies, notably the BMA, and political actors (Conservative and Labour MPs and ministers), that sought compulsory medical examinations at the ports of entry. Through the 1950s, the allegation that migrants represented a high proportion of new cases seen at local chest clinics was mobilised and popularised by contemporary newspapers in support of a “moral panic” on the question of migration and tuberculosis. Supporters of medical examinations pointed to the action that other countries had taken, most obviously Australia. Research was concerned with tuberculosis among Irish, Pakistani, and Indian migrants in London, Birmingham, Bradford, and Wolverhampton. These studies seemed to show that most tuberculosis was imported, and control might be supported by early detection of disease through medical examinations at the ports of entry.¹⁶ From the late 1950s, the BMA exerted pressure on the Ministry of Health that all migrants should have medical examinations at the ports of entry, a policy endorsed by Enoch Powell as Minister of Health in March 1962.¹⁷

To an extent, this political pressure was reflected in policy formation and implementation. The 1962 Commonwealth Immigrants Act gave powers to port health authorities and immigration officers to refer certain categories of people to medical inspectors for examination. A Commonwealth citizen could be refused admission if it appeared “that he is a person suffering from mental disorder, or that it is otherwise undesirable for medical reasons that he should be admitted”.¹⁸

Entry could be refused on account of medical reasons, especially mental disorder, tuberculosis, venereal disease, leprosy, and trachoma, or to people who for medical reasons were unable to support themselves.¹⁹ Subsequently, the provisions for medical examinations and chest radiographs were extended to the families and dependants of long stay migrants. Furthermore, from February 1965, chest radiographs were introduced on an experimental basis at London’s Heathrow Airport.

Nevertheless, the pressure in favour of compulsory medical examinations was resisted by the Ministry of Health and other governmental departments. The emphasis on screening at the port of entry was gradually subverted in favour of a policy whereby the addresses of arriving migrants were forwarded to medical officers of health in the district of intended residence. Evidence shows that neither the experimental radiography scheme at Heathrow Airport, nor the port of arrival system, were effective as mechanisms for detecting early cases. Firstly, radiography continued to be a minor part of medical examinations—only a small proportion of those “medically examined” at Heathrow had chest radiographs.²⁰ Secondly, the addresses given under the port of arrival system were often incorrect or temporary, and health visitors found tracing migrants was laborious and time consuming. Only around two thirds of arriving migrants were followed up by the staff of local public health departments.²¹

There were several reasons for the particular stance adopted by the Ministry. Firstly, in the mid-1950s particularly, the Ministry believed that the “problem” was a small one, confined essentially to Irish migrants. Secondly, there were the advantages of comparatively open borders to a government concerned about a growing economy in which the demand for labour outstripped supply. Thirdly, civil servants at the Ministry of Health pointed out the costs and practical problems involved in setting up a compulsory screening system—the difficulties involved in attempting to radiograph large numbers of people, and the linguistic and other administrative problems that this would have created. Here the national shortages of radiologists and radiographers were crucial. Fourthly, civil servants were aware that tuberculosis was as likely to be reactivated in conditions of overcrowding and socioeconomic disadvantage as to be imported. Fifthly, Powell remained isolated within the cabinet on the screening issue, and there was the opposition from other government departments, notably the

Home Office, Ministry of Aviation, and Commonwealth Relations Office.²²

Many of the same factors seem uppermost in the debate on tuberculosis, migration, and medical examination today. These include the close association in the popular mind between migration and infectious disease; the emphasis on the importance of "protecting" public health in the UK; the emphasis on the costs of care for tuberculosis patients; the importance to the economy of migration; and the interest in the experience of other countries. At the same time, there are important changes, with current policy anticipating a shift to the Australian model of pre-entry screening. While the legislative framework in the UK remains the same (still essentially the 1971 Immigration Act), its coercive nature may change. There is also an important political discourse on health tourists, those allegedly visiting the UK to use the NHS. The history of both countries illuminates the factors that drive policy and practice in the past and the present. The tradition of regulating public health through migration law and policy is one of the important historical and contemporary differences between the current Australian and UK models of screening. There is little epidemiological evidence to rationalise either current UK screening processes or the compulsory pre-entry model; these systems are often more about migration and asylum politics rather than the public health. It is

these cultural and political factors, refracted through science, medicine, and epidemiology, that are uppermost in the long history, the present and the future, of medicolegal border control. Sometimes, history can help explain what epidemiology cannot.

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APHORISM OF THE MONTH

Community organisers beware: there is no such thing as an unorganised community.

Lowell Levin